MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9792 **CERTIFICATE OF DEATH** 09763

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 30yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 20I Grand Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Cumberland
d. STREET ADDRESS: 20I Grand Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rudolph — Middle: LeGard — Last: Appell

4. DATE OF DEATH: Month: Sept. — Day: I, — Year: 19 60

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 6, I9I5

9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Martinsburg, W.Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clifton A. Appell

14. MOTHER'S MAIDEN NAME: Oddie L. Bevins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): War II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Betty Ann Appell — Address: 20I Grand Ave. (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 420.1
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 28 May, 19 60 to 1 Sept, 19 60, that I last saw the deceased alive on 1 Sept, 19 60, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David T Rees M.D. — ADDRESS (Street, city or town, state): 702 Montgomery Ave Cumberland MD — DATE SIGNED

PHYSICIAN'S NAME (Type): David T. Rees 702 Montgomery Ave. Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-4-60
22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James Scarpelli — ADDRESS: Cumberland Md

24a. REC'D BY REGISTRAR DATE SEP 6 '60

24b. REGISTRAR'S SIGNATURE: Clarence S. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9753

09764

CERTIFICATE OF DEATH

M

060

I

0

1

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND 02
d. STREET ADDRESS: 207 SPRING STREET 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JEHU; Middle GUY; Last BARNES

4. DATE OF DEATH: Month SEPTEMBER; Day 12; Year 19 60

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY 9, 1897

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer & Orchard worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA Barnes Mill, S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: FRANK PIERCE BARNES

14. MOTHER'S MAIDEN NAME: MARY E. HARDY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): War I

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CARCINOMA OF COLON	1 YR.
DUE TO (b)	METASTASIS TO LUNGS AND LIVER	4 MONTHS
DUE TO (c)	PANCREATIC METASTASIS WITH JAUNDICE	2WKS.

153.8

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JULY 27, 1960, to SEPT 12, 1960, that (I) (we) last saw the deceased alive on AUG 7, 1960, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard E. Schindler M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. R. SCHINDLER

22d. ADDRESS: 69 GREENE ST CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 15, 1960
23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem.
23d. LOCATION (City, town, or county) (State): Points, West Va.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F Scarpelli 108 Virginia Ave.

25a. REC'D BY REGISTRAR DATE: SEP 19 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9794

CERTIFICATE OF DEATH

09765

M

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 21 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL - MEMORIAL AVENUE

060

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
02
d. STREET ADDRESS: 679 FAYETTE STREET
1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NETTIE Middle VIRGINIA Last BLOSS

4. DATE OF DEATH: Month SEPTEMBER Day 27 Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 12, 1888

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): BERKELEY SPRINGS, W. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W. GROVE

14. MOTHER'S MAIDEN NAME: SARAH HOVERMALE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Thyroid with Ostenes
194X
DUE TO (b): Metastasis to Lungs.
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 6 months.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6 Sept, 1960, to 27 Sept-60, that (I) (we) last saw the deceased alive on 26 Sept 1960, and that death occurred at 3:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: W. Alfred Van Ormer M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. W. A. VAN ORMER

22d. ADDRESS: 122 SO. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 30, 1960

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Prk

23d. LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George,

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9795

09766

1

(M)

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND

c. LENGTH OF STAY IN 1b: 49 DAYS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

d. STREET ADDRESS: 417 FAYETTE STREET

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY Middle: E. Lost: BOETTNER

4. DATE OF DEATH: Month: SEPTEMBER Day: 7 Year: 19 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 22, 1889

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~NONE~~ Retired Custodian, Alleg. High School

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARTINSBURG, W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE W. ALBERT

14. MOTHER'S MAIDEN NAME: IDA SUSAN RAINEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic Carcinoma - Ovarian — INTERVAL BETWEEN ONSET AND DEATH: 18 months.

175.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ~~Aug~~ 1959 to 9:00 A.M. Sept 1960 that (I) (we) last saw the deceased alive on Sept 7 1960 and that death occurred at 4:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Overton Himmelwright (M.D.)

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/8/60

22c. PHYSICIAN'S NAME (Type): DR. OVERTON HIMMELWRIGHT

22d. ADDRESS: 133 Virginia Ave Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/9/1960

23c. NAME OF CEMETERY OR CREMATORY: St. Peter & Pauls Cemetery

23d. LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 13 60

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9796

CERTIFICATE OF DEATH

09767

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 12 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 36 STOYER STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle H. Last BOND

4. DATE OF DEATH: Month SEPTEMBER Day 23 Year 19 60

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 28, 1887

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: P.E.Sub-Station

11. BIRTHPLACE (State or foreign country): FROSTBURG, MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: THOMAS BOND

14. MOTHER'S MAIDEN NAME: LUCILLA APPLEDORE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-10-4711A

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Vascular Disease
DUE TO (b): Complicated by acute Post Partum
DUE TO (c): Uremia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Days / 2-11-60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastric resection for penetrating (9-17-60) ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-16- 19 60 to 9-23- 19 60, that (I) (we) last saw the deceased alive on 9-22-60 and that death occurred at 12:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W. F. Williams M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-23-60

22c. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22d. ADDRESS: Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-25-60
23c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park
23d. LOCATION (City, town, or county) (State): Frostburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: L. R. Durst
ADDRESS: Frostburg, Md.
25a. REC'D BY REGISTRAR DATE: SEP 26 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09768

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

979 Item 4 FilmG271 9-13-60 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 75 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 782 MacDonald Terrace

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 782 MacDonald Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle Last BUCHANAN

4. DATE OF DEATH: Month Sept. Day 1, Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 28,1866

9. AGE (In years last birthday): 94 yrs.

IF UNDER 1 YEAR: Months ____ Days ____

IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alexander Rhoads

14. MOTHER'S MAIDEN NAME: Cathering Poister

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mrs. Charles R. Nuzum, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CORONARY SCLEROSIS — ———
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: SEPT. 1, 1960

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 3, 1960
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Maudoleum
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight
ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: SEP 6 '60
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9798 — 09769

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 15 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY
d. STREET ADDRESS: RT. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First THOMAS — Middle Marvin — Last CARDER

4. DATE OF DEATH: Month SEPTEMBER — Day 22 — Year 19 60

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 26, 1897

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED carman

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.CO.

11. BIRTHPLACE (State or foreign country): POINTS, W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT CARDER

14. MOTHER'S MAIDEN NAME: BETTY WATSON Elizabeth J. Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. I

16. SOCIAL SECURITY NO.: 705-09-9628

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of lungs, metastatic, primary — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO (b): site unknown
DUE TO (c):

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Emphysema. Cor pulmonale

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1 - 23 - 19 54 to 9 - 22 - 19 60 that (I) (we) last saw the deceased alive on 9 - 21 - 19 60 and that death occurred at 2:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Ralph L. Ballin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9-23-60

22c. PHYSICIAN'S NAME (Type): DR. BALLIN

22d. ADDRESS: 62 Greene St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Sept. 25, 1960 — 23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem. — 23d. LOCATION (City, town, or county) (State): Points, W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 26 '60 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9834 09770

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: MINERS-HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): GRANTSVILLE-RD.
d. STREET ADDRESS: 11X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Loman Last: Cobaugh

4. DATE OF DEATH: Month: September Day: 9 Year: 1960

5. SEX: M

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 25-1890

9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY: INN-KEEPER

11. BIRTHPLACE (State or foreign country): JOHNSTOWN, PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: EDGAR-COBAUGH

14. MOTHER'S MAIDEN NAME: MINNIE-JOHNS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 240-42-4136

17. INFORMANT: Mary Geist Address: Johnstown Pa. 447 Kennedy Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o): Arterio-sclerotic Cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 6 Mos.

DUE TO (b):

Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): R. Hemiplegia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-20 1960 to 9-9 1960 that (I) (we) last saw the deceased alive on 9-9 1960 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: H.C. Diehl. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/9/60

22c. PHYSICIAN'S NAME (Type): H.C. Diehl, M.D.

22d. ADDRESS: Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: SEPT. 12-1960

23c. NAME OF CEMETERY OR CREMATORY: SALISBURY-I.O.O.F.

23d. LOCATION (City, town, or county) (State): SALISBURY-SOMERSET-Co. PA.

24. FUNERAL DIRECTOR'S SIGNATURE: Stanley M. Thomas ADDRESS: Salisbury, Pa.

25a. REC'D BY REGISTRAR DATE: SEP 14 '60

25b. REGISTRAR'S SIGNATURE: Arthur E. Kinzie

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9799 09771

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2/25/56
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 703 Elm Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: E.; Last: Couter

4. DATE OF DEATH: Month: September; Day: 26,; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/17/1879

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Wright

14. MOTHER'S MAIDEN NAME: Joann Zimmerly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: P. O. Box 599, Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): General Arteriosclerosis, — ?
DUE TO (c): Chronic Nephritis — ?

592 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile Deterioration.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/25/56 19___, to 9/26/60 19___, that (I) (we) last saw the deceased alive on 9/24/60 19___, @ 5:45 A.M., and that death occurred at ___M, from the causes and on the date stated above.

22a. SIGNATURE: James E. McLean M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 9/26/60

22c. PHYSICIAN'S NAME (Type): Dr. James E. McLean

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/28/1960

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 29 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9804

CERTIFICATE OF DEATH

09772
Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland c. LENGTH OF STAY IN 1b: 8 mos. 24 das. 02	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sylvan Retreat	d. STREET ADDRESS: 346 Central Avenue e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Milford	Luther	Crabtree	September	23	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		6/5/81	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Policeman	City of Cumberland	Maryland, Gilpintown	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Crabtree	Kathleen Springstead

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no		William M. Crabtree, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492 Primary atypical pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

290.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) 432 Chronic hypertensive degeneration — ?

DUE TO (c) 290 Senile psychosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 304 Senile psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour o. m. p. m.	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I certify that I attended the deceased from Dec. 30, 19 59 to Sept. 23, 19 60 that I last saw the deceased alive on Sept. 22, 19 60, and that death occurred at 3:05 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St, — DATE SIGNED: 9/23/60

PHYSICIAN'S NAME (Type): James E. McLean, M.D. — 49 Greene St., Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9/25/60	Hillcrest Burial Park	Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
John J. Hafer, Cumberland, Maryland	SEP 27 '60	Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9854 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09773

Reg. Dist. No.

M

PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

X

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Raymond	Payne	Cutter	September	14	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		August 26,1918	42 yrs.		

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Allegany Ballistics Laboratory	Midland, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Russell Cutter	Helen Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
	220-10-1392	Mrs. Raymond Cutter Midland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — Interval between onset and death: Sudden

DUE TO (b): Coronary Sclerosis with Thrombosis, Left — ----

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify thot I took chorge of the remoins described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, ond find that deoth resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined couse ☐.

ACTUAL SIGNATURE: W O McLane M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DATE SIGNED

EXAMINER'S NAME (Type) W. O. McLane, Jr. M.D. Asst. — DEPUTY MEDICAL EXAMINER ☒ Sept. 14, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9.16/60	Sunset Memorial Park	Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
George Eichhorn Lonaconing, Md.	SEP 19 '60	Clarence L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9852 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09774

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Barton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Douglas Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: STANLEY — Middle: LUTHER — Last: DAVIS

4. DATE OF DEATH: Month: 9/16/1960 — Day — Year: 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/10/22

9. AGE (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Celanese Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Barton, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Davis

14. MOTHER'S MAIDEN NAME: Jane Kirk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 2nd. World War

16. SOCIAL SECURITY NO.: 215-14-6385

17. INFORMANT: Mrs. Stanley Davis (WIFE) — Address: Lonaconing, M

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO (b): CORONARY SCLEROSIS WITH THROMBOSIS — -----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 16, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/19/1960
22c. NAME OF CEMETERY OR CREMATORY: MT. VIEW CEMETERY
22d. LOCATION (City, town, or county) (State): MOSCOW, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN — ADDRESS: LONACONING, MD.

24a. REC'D BY REGISTRAR DATE: SEP 19 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 9835 09775

M

061

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 12 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt. Savage
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First J. Middle Owen Last Deffenbaugh

4. DATE OF DEATH: Month September Day 24th, Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 26th, 1883
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.Car Repairman
10b. KIND OF BUSINESS OR INDUSTRY: C&PRR
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John G. Deffenbaugh
14. MOTHER'S MAIDEN NAME: Jane Hitchins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 712-14-1700
17. INFORMANT Address: Mrs.Roy F. Growden, Mt. Savage, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Evisceration	7 day
DUE TO (b)	Acute Suppurative Cholecystitis	13days
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5855X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 12, 1960 to Sept. 24, 1960, that (I) (we) last saw the deceased alive on Sept. 24, 1960, and that death occurred at 11:30 A. M., from the causes and on the date stated above.

22a. SIGNATURE: Hilda J. Walters, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Hilda J. Walters, M
22d. ADDRESS: 48 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-27-60
23c. NAME OF CEMETERY OR CREMATORY: M. E. Cemetery
23d. LOCATION (City, town, or county) (State): Mt. Savage, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. P. Durst
ADDRESS: Frostburg, Md.
25a. REC'D BY REGISTRAR DATE SEP 29 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9801 09776

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: SACRED HEART

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY
d. STREET ADDRESS: 34 KNOBLEY ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ALONZO	WISE	DORSEY	SEPT.	9,	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE		2-28-95	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chief Caller	W.MARYLAND R.R.	MARYLAND, Hagerstown	U.S.A.

13. FATHER'S NAME: ASHBY DORSEY
14. MOTHER'S MAIDEN NAME: Clara Proctor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No.		Richard Dorsey 34 Knobley St., Ridgeley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia due to — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO (b): Hypertensive C.V. Dis., — 2 years

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c): Mental Hemorrhage & Anemia — 2 weeks

443 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 19 45 to Sept 9 19 60 that (I) (we) last saw the deceased alive on Sept 5 19 60 and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
B. M. Schindler			9/9/60.

22c. PHYSICIAN'S NAME (Type): DR. B.M.SCHINDLER
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	9/11/60	Hillcrest Burial Park	Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles L. George	Cumberland, Md.	SEP 13 '60	Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9882 — Reg. Dist. No. 09777

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Va. — b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgeley
d. STREET ADDRESS: 34 Knobley St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Vivian — Middle: Lee — Last: Dorsey
4. DATE OF DEATH: Month: September — Day: 9 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 12, 1894
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: John J. Hoffman
14. MOTHER'S MAIDEN NAME: Elda Crawthers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Richard Dorsey, 34 Knobley St. Ridgeley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CORONARY SCLEROSIS — ----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autapsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Noturol causes ☒ Accident ☐, Suicide ☐, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Benedict Skitarelic M. D.
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 9, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 11, 1960
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Charles L. George, Cumberland, Md.
24a. REC'D BY REGISTRAR — DATE: SEP 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9803 Item 16 FilmG271 9-23-60 at

09778 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 12 HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ECKHART
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PERRY Middle Last DUDLEY

4. DATE OF DEATH: Month SEPT. Day 17, Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCT. 26, 1880
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. COAL MINER
10b. KIND OF BUSINESS OR INDUSTRY: F'BG. FUEL CO.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM DUDLEY
14. MOTHER'S MAIDEN NAME: ELIZABETH LAMMERT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-01-3680
17. INFORMANT Address: MRS. MARY DUDLEY, ECKHART, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 Hrs
DUE TO (b): Arteriosclerotic Vascular disease — —
DUE TO (c):

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: Sept. 18, 1960
EXAMINER'S NAME (Type): DR. BENEDICT SKITARELIC

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9-19-1960
22c. NAME OF CEMETERY OR CREMATORY: ECKHART CEMETERY
22d. LOCATION (City, town, or county) (State): ECKHART, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst
ADDRESS: FROSTBURG, MD.
24a. REC'D BY REGISTRAR DATE: SEP 20 60
24b. REGISTRAR'S SIGNATURE: Clifton L. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9853 — Reg. Dist. No. 09779

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Moscow
c. LENGTH OF STAY IN 1b: 3 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1 Mi W. of Moscow

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Barton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Maurice — Middle: Van Buren — Last: Fazenbaker

4. DATE OF DEATH: Month: Sept — Day: 1 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 4, 1918

9. AGE (In years last birthday): 42 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Timber cutter

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oliver C. Fazenbaker

14. MOTHER'S MAIDEN NAME: Fanny Belle Grove

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert Fazenbaker-Gilmore, Md. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): TRAUMATIC ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: 5 Min.
DUE TO (b): COMPRESSION OF CHEST AND ABDOMEN — 5 Min.
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c): Pinned under overturned tractor — "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Pinned under overturned tractor

20c. TIME OF INJURY: Hour: 11:30 a. m. p. m. — Month, Day, Year: Sept 1 1960

20d. INJURY OCCURRED: While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town): Moscow — (County): Alleg. — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W O McLane M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): W. O. McLane, M.D. asst — Sept. 1, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/4/60
22c. NAME OF CEMETERY OR CREMATORY: Philos Cem.
22d. LOCATION (City, town, or county): Westernport (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Beal — ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR DATE: SEP 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9836

CERTIFICATE OF DEATH

Reg. Dist. No. 09780

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg,
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institutian: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eckhart,
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: G. — Last: Harriman

4. DATE OF DEATH: Month: September — Day: 17th, — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 26th, 1876

9. AGE (In yeors last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Bannatyne

14. MOTHER'S MAIDEN NAME: Annie Glenn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: Address W. Main Street, Mrs. Michael Taccino, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs?
420.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE, 1958, to 9/17, 1960, that I last saw the deceased alive on 9/17, 1960, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Rothstein M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED:

PHYSICIAN'S NAME (Type): Martin M. Rothstein, — " 48 Broadway, Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-20-60
22c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery
22d. LOCATION (City, town, or county) (State): Eckhart, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst — ADDRESS: Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: SEP 22 '60

24b. REGISTRAR'S SIGNATURE: Cirthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9804 — 09781

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 620 ELWOOD STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First WALTER — Middle H — Last HUGHES

4. **DATE OF DEATH**: Month SEPTEMBER — Day 22 — Year 19 60

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 14, 1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: Bricklayer

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSEPH HUGHES

14. MOTHER'S MAIDEN NAME: MINTA JULIA DAMM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-8120

17. **INFORMANT** Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary infarct	3 days
DUE TO (b)	Generalized Arteriosclerosis	yrs
DUE TO (c)	Cardiac decompensation	3 days

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 1955 A.M. to 9/22 19 60, that (I) (we) last saw the deceased alive on 9/22 19 60, and that death occurred at 5:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: George M Simons M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. G. M. SIMONS

22d. ADDRESS: Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 24, 1960

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town, or county) (State): Cumberland Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein, Inc. V.P.

ADDRESS: Cumberland Md

25a. REC'D BY REGISTRAR DATE: SEP 26 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

Mgr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9805 — Reg. Dist. No. 09782

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, near Cumberland
d. STREET ADDRESS: Rt.3, M24, Bedford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAYME — Middle ALICE — Last HURT

4. DATE OF DEATH: Month SEPT. — Day 16 — Year 1960

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: November 2, 1895 — 9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Fairhope, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Silas Shroyer
14. MOTHER'S MAIDEN NAME: Martha Emerick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Fred Hurt, M24, Rt.3, Bedford Rd., Cumberland Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	PERICARDIAL HEMORRHAGE	1 Hr.
DUE TO (b)	RUPTURE OF DISSECTING ANEURYSM	1 Hr.
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: SEPT. 16, 1960

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept.19,1960
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE SEP 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9806

09783

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 12/29/51
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Moscow
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: J. — Last: Hyde

4. DATE OF DEATH: Month: September — Day: 28, — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/16/1893

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED: School Teacher - Teaching

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alfred J. Hyde

14. MOTHER'S MAIDEN NAME: Catherine Mowbray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: P.O.Box 599, Address: Cumberland, Md.
Allegany County Infirmary Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Hypostasis, — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
DUE TO (b): Chronic Myocarditis — ?
DUE TO (c): Chronic Osteoarthritis — ?

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse lost. 422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 12/29/51, 19___, to 9/28/60, 19___, thot (I) (we) lost saw the deceased alive on 9/28/60 19___ @ 6:33 P.M., and that death occurred ot ___ M, from the causes and on the dote stoted above.

22a. SIGNATURE: James E. McLean M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒ — 22b. DATE SIGNED: 9/29/60

22c. PHYSICIAN'S NAME (Type): Dr. James E. McLean

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/1/60

23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill

23d. LOCATION (City, town, or county) (State): Moscow, d

24. FUNERAL DIRECTOR'S SIGNATURE: E. L. Boal

ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

9806 13758

Allegany Maryland Allegany

Cumberland 12/29/51 Moscow

Allegany County Infirmary x

Ethel J. Hyde September 28, 1960

x

Female White 7/16/1893 67

RETIRED: School Teacher - Teaching Maryland U. S. A.

Alfred J. Hyde Catherine Mowbray

P.O.Box 599, Cumberland, Md.

Allegany County Infirmary Records

12/29/51 9/28/60

9/28/60 @ 5:33 P.M.

x x x 9/29/60

Dr. James E. McLean 49 Greene St., Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9807 Reg. Dist. No. 09784

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland (Bowling Green
c. LENGTH OF STAY IN 1b: 5yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowling Green Maryland X
d. STREET ADDRESS: Bowling Green Maryland 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willard; Middle: Madison; Last: Jeffries

4. DATE OF DEATH: Month: Sept.; Day: 6; Year: 19 60

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 5, 1915

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Experimental

10b. KIND OF BUSINESS OR INDUSTRY: Textile

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Porter Jeffries

14. MOTHER'S MAIDEN NAME: Eveline Marie Sharretts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-07-5274

17. INFORMANT: Ruth Jeffries — Address: Bowling, Green Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION, RIGHT — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO (b): CORONARY THROMBOSIS AND SCLEROSIS — -----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot I took chorge of the remains described obove, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that deoth resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: SEPT. 6, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-9-60
22c. NAME OF CEMETERY OR CREMATORY: Indian Mount Cem.
22d. LOCATION (City, town, or county) (State): Romney, W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli
ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09785

9854

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route 3, Bedford Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 417 N. Centre Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GLEN Middle SIMONS Last JOHNSON

4. DATE OF DEATH: Month September Day 4 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 23, 1896
9. AGE (In years lost birthday): 64 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Tube Inspector
10b. KIND OF BUSINESS OR INDUSTRY: Kelly-Springfield Tire Co.
11. BIRTHPLACE (State or foreign country): Ellerslie, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Johnson
14. MOTHER'S MAIDEN NAME: Clara Simons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 214-07-0753
17. INFORMANT: Mrs. Richard Kenney Address: Rt. 3, Bedford Road Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
(b): Arteriosclerotic cardiovascular disease — Years
DUE TO
(c):

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic cor pulmonale

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 19 55 to August 19 60, that (I) (we) last saw the deceased alive on August 9 1960, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: G. Overton Himmelwright M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/6/60
22c. PHYSICIAN'S NAME (Type): G. Overton Himmelwright M.D.
22d. ADDRESS: 133 Va. Ave., Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept, 7, 1960
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland
25a. REC'D BY REGISTRAR DATE: SEP 13 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 [illegible] should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9808 — 09786

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH a. COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Alleghany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL	d. STREET ADDRESS: 711 Arundel St. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
IDA	MAE	JOHNSON	SEPT.	21	19 60

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	WHITE		JUNE 17, 1879	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house wife	Own Home	WEST VIRGINIA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
RICHARD JEFFERYS	MELINDA SNYDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	none	PATIENTS CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive heart failure	8 weeks
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 420.0 — DUE TO (b)	arteriosclerotic heart disease	6 mos
DUE TO (c)	generalized arteriosclerosis	2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 12:20 PM from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
L. Brings			

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
LEWIS BRINGS, MD.	57 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
burial	9/24/60	Oakland Memetery	Oakland Maryland

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Gerald N. Minnich	Oakland, Maryland	SEP 26 '60	Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9809

10896

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 MINUTES
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: HAMPSHIRE
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): PAW PAW
d. STREET ADDRESS: 25X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BABY Middle BOY Lost KAYLOR

4. DATE OF DEATH: Month SEPTEMBER Day 14 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPTEMBER 14, 1960

9. AGE (In years lost birthday) — yrs.
IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min. 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: RONAND E. KAYLOR

14. MOTHER'S MAIDEN NAME: ANITA MAE STROSNIDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 770.0 Erythroblastosis fetalis
DUE TO (b): RH sensitivity in mother
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1 minute

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-14 1960, to 9-14 1960, that (I) (we) last saw the deceased alive on 19, and that death occurred at 5:20 from the causes and an the date stated abave.

22a. SIGNATURE: W Royce Hodges M.D. ATTENDING PHYS. ✓ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. ROYCE HODGES

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 9-16-60

23c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital

23d. LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

25a. REC'D BY REGISTRAR DATE OCT 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A15 (4) 1SM 9/59

2060203XV5

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9810

09787

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 30 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: SACRED HEART

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 419 WASHINGTON ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle BERNADETTE Last KELLY

4. DATE OF DEATH: Month 9- Day 20 Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-14-1900

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOOK KEEPER

10b. KIND OF BUSINESS OR INDUSTRY: Shoe Business

11. BIRTHPLACE (State or foreign country): Westernport, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN KELLY

14. MOTHER'S MAIDEN NAME: Ella Footen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Frank T. Kelly Address: 16 N. Chase St., Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line far (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

465X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Adeno Carcinoma of the left Lung

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Manth, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 5 Aug 1960, to 19 Sept 1960 thot (I) (we) last saw the deceased alive on 19 Sept 1960, and that death occurred at 7:30 A M, from the causes and on the date stated above.

22a. SIGNATURE: L M Glick M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/21/60

22c. PHYSICIAN'S NAME (Type): DR.L.M.GLICK

22d. ADDRESS: 126 N. Smallwood St. Cumb. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/22/60
23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul's Cem.
23d. LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George
ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 23 '60

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09788

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Zihlman
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hope Road

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Zihlman
d. STREET ADDRESS: Hope Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FANNIE Middle ELLEN Last LANCASTER

4. DATE OF DEATH: Month 9 Day 2 Year 1960.

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-14-1870

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Borden Mines

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Skidmore

14. MOTHER'S MAIDEN NAME: Susan Weitzel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: William Lancaster — Address: Frostburg Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Fracture Rt Humerus — 10 Days
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell in Home

20c. TIME OF INJURY: Hour 5:00 p. m. Month, Day, Year Aug 23 1960

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Res. Home

20f. (City or Town) Zihlman (County) Allegany (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W.O. McLane M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept 3 1960

EXAMINER'S NAME (Type): W.O. McLane asst

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-5-60
22c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery
22d. LOCATION (City, town, or county) (State): Eckhart Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Burdett H. Montgomery — ADDRESS: Hafer Funeral Home 23 East Main, Frostburg

24a. REC'D BY REGISTRAR DATE SEP 7 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kreps

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9841

09789

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 355 Bedford St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 355 Bedford St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DORSEY Middle DALTON Last LEPLEY

4. DATE OF DEATH: Month Sept. Day 7 Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 24, 1884

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. RR

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Millard F. Lepley

14. MOTHER'S MAIDEN NAME: Louise Burkett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705 09 4195

17. INFORMANT: Mrs. Cora Lepley Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia - Carcinomatosis	10 days
DUE TO (b)	Prostatic Carcinoma	3 years
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-12 1960, to 9-7 1960 that (I) (we) last saw the deceased alive on 9-7 1960, and that death occurred at 7.15 M, from the causes and on the date stated above.

22a. SIGNATURE: William P James M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): William P. James, M. D.

22d. ADDRESS: N. Centre St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 10, 1960

23c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery

23d. LOCATION (City, town, or county) (State): Artemas, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE SEP 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9812

09790

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 29DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND,
d. STREET ADDRESS: 342 BALTIMORE AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

062

3. NAME OF DECEASED (Type or print): First BESSIE — Middle E. — Last LINNAWEAVER

4. DATE OF DEATH: Month 9 — Day 19 — Year 19 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: April 8, 1892

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: (DECEASED) William Imes

14. MOTHER'S MAIDEN NAME: Rachael Twigg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: CHART Katherine Scheeler, Baltimore, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism
DUE TO (b): Secondary to Pulmonary Congestion
DUE TO (c): Secondary to Vaginal Hysterectomy

633 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 21 1960, to Sept. 19 1960 that (I) (we) last saw the deceased alive on Sept. 19 1960, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Carlton Brinsfield M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. C. BRINSFIELD

22d. ADDRESS: 232 Baltimore Ave Cumberland

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 21, 1960

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE SEP 22 '60

25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9813

09791 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 417½ N. Centre St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 02
d. STREET ADDRESS: 417½ N. Centre St. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Agnes Middle: Williams Last: Lottig
4. DATE OF DEATH: Month: Sept. Day: 25 Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Jan. 17. 1875
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas J. Lottig
14. MOTHER'S MAIDEN NAME: Ellen Armstrong Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Miss. Anna E. Lottig
Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: Unk
DUE TO
(b): — 2-2-60
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-22, 1960 to 9-25, 1960, that I last saw the deceased alive on 6-17, 19 60, and that death occurred at 10:20 a. m. from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Williams M.D.
ADDRESS (Street, city or town, state): Cumberland Md
DATE SIGNED: 9-27-60

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 28, 1960
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum
22d. LOCATION (City, town, or county) (State): Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein, Inc.
ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9814

CERTIFICATE OF DEATH

09792

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

M

060

I

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: HAMPSHIRE
c. CITY OR TOWN (If outside carporate limits, write RURAL ond give nearest town): PAW PAW
85X-3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MAXINE Middle A. Last MC KEE

4. DATE OF DEATH: Month SEPTEMBER Day 23 Year 19 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 29, 1936

9. AGE (In years last birthday): 24 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JAMES W. MC KEE

14. MOTHER'S MAIDEN NAME: BRENT L. HARDY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO
492X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Bilateral Pneumonia. — 30 hours.
DUE TO
(c): Cerebral Palsy — Birth.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 1959, to Sept 23, 1960, that (I) (we) last saw the deceased alive on Sept 23 1960 and that death occurred at 7:45PM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/25/60

22c. PHYSICIAN'S NAME (Type): DR. OVERTON HIMMELWRIGHT

22d. ADDRESS: 133 Va Ave, Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: SEPT. 27, 1960
23c. NAME OF CEMETERY OR CREMATORY: CAMP HILL CEM.
23d. LOCATION (City, town, or county) (State): PAW PAW, W. VA.

24. FUNERAL DIRECTOR'S SIGNATURE: PARKS-JOHNSON, ADDRESS: BERKELEY SPGS. W. VA.

25a. REC'D BY REGISTRAR DATE SEP 30 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9845 — Reg. Dist. No. 09793

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: D. O. A. Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cresaptown,
d. STREET ADDRESS: Along Rt. # 220
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emory — Middle: Melvin — Last: McKenzie
4. DATE OF DEATH: Month: Sept. — Day: 20, — Year: 19 60
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 8, 1900
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Weighmaster
10b. KIND OF BUSINESS OR INDUSTRY: Kelly-Tire Co.
11. BIRTHPLACE (State or foreign country): Cresaptown, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: George J. McKenzie
14. MOTHER'S MAIDEN NAME: Mary Hershberger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: 214-07-0213
17. INFORMANT — Address: Mrs. Elizabeth McKenzie Cresaptown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Coronary Artery Disease — 5 yrs
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State): Cumberland Allegany Md.

21. I certify that I attended the deceased from 2/3/54, 19____, to 9/20/60, 19____, that I last saw the deceased alive on 9/13/60, 19____, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard J. Williams M.D. — ADDRESS (Street, city or town, state): 122 So. Centre St., — DATE SIGNED: 9/22/60
PHYSICIAN'S NAME (Type): Richard J. Williams M.D. — Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/22/60
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: SEP 23 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9816

09794

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 18 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PIEDMONT
d. STREET ADDRESS: 42 ASHFIELD STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

85X-3

060

3. NAME OF DECEASED (Type or print): First TAMMY — Middle RAY — Last METZ

4. DATE OF DEATH: Month SEPTEMBER — Day 25, — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 15, 1960

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 1 Days 41 — IF UNDER 24 HRS. Hours = 1 mo. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): KEYSER, W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: RAYMOND EDWARD METZ

14. MOTHER'S MAIDEN NAME: REBA JEAN ARTHUR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b): Congenital Heart — Birth
DUE TO (c): Prematurity - weight 4 lbs -

754.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hydrocephalus, Congenital Intestinal Atresia. — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-7-60 to 9-25-60, that (I) (we) last saw the deceased alive on 9-24-60 and that death occurred at 1:58 A.M. from the causes and on the date stated above.

22a. SIGNATURE: H.W. Eliason M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. H.W. ELIASON

22d. ADDRESS: 203 Green St Cumberland Md 9/26/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 9/27/60 — 23c. NAME OF CEMETERY OR CREMATORY: Rose Hill — 23d. LOCATION (City, town, or county) (State): Moscow Md

24. FUNERAL DIRECTOR'S SIGNATURE: E. L. Bittel — ADDRESS: Westernport, Md

25a. REC'D BY REGISTRAR DATE SEP 30 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

9 V V V V V V X V V

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9817

CERTIFICATE OF DEATH

09795

M

062

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1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 225 COLE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle MARGARET Last MILLER

4. DATE OF DEATH: Month SEPT. Day 9, Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-6-93
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES LEONARD
14. MOTHER'S MAIDEN NAME: JANOCA Marie Jacobs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: PT'S CHART. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO (b): Hypertensive C.V. Disease — years
DUE TO (c): Uremia — 1 week

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June 1945, to Sept 9, 1960, that (I) (we) last saw the deceased alive on Sept 1960, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: B M Schindler M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/9/60
22c. PHYSICIAN'S NAME (Type): DR. B.M.SCHINDLER MD
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/12/60
23c. NAME OF CEMETERY OR CREMATORY: St. Patricks Cem.
23d. LOCATION (City, town, or county) (State): Cumberland Md

24. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc.
ADDRESS: Cumb. Md.
25a. REC'D BY REGISTRAR DATE: SEP 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9856

09796

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McCoole
c. LENGTH OF STAY IN 1b: 3 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McCoole
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: William — Last: Moore

4. DATE OF DEATH: Month: Sept. — Day: 25 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 22, 1882

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alonzo Moore

14. MOTHER'S MAIDEN NAME: Sadie Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs John W. Moore, McCoole, Md. — Address:

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic — INTERVAL BETWEEN ONSET AND DEATH: 5 Years

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Month, Day, Year — Hour: o. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Feb 11, 1955, to Sept 25, 1960, that (I) (we) last saw the deceased alive on Sept 24, 1960, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Paul R Wilson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Sept. 26, 1960

22c. PHYSICIAN'S NAME (Type): Paul R. Wilson M.D.

22d. ADDRESS: Piedmont, W. Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/28/60

23c. NAME OF CEMETERY OR CREMATORY: Kight Cemetery

23d. LOCATION (City, town, or county) (State): Cross, Mineral ct., W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: E. L. Boal — ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR: DATE: SEP 27 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

98:57

CERTIFICATE OF DEATH

09797

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 292 National Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale
d. STREET ADDRESS: 292 National Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis — Middle: Alan Gordon — Last: Murray

4. DATE OF DEATH: Month: September — Day: 11 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 26, 1876

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician & Surgeon

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Mosley Murray

14. MOTHER'S MAIDEN NAME: Mabel Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Gertrude Murray — Address: 292 National Highway, LaVale, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral thrombosis with right hemiplegia.	approx. 4 da.
DUE TO (b)	Arteriosclerotic cardiovascular disease.	15 years
DUE TO (c)	Generalized arteriosclerosis.	??

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 18 February 19 59, to 11 September 19 60 that (I) (we) last saw the deceased alive on 11 Sept. 19 60, and that death occurred at 3.05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W. Alfred VanOrmer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/11/60

22c. PHYSICIAN'S NAME (Type): W. Alfred VanOrmer M.D.

22d. ADDRESS: 122 So. Centre St., Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 12, 1960

23c. NAME OF CEMETERY OR CREMATORY: Restlawn Burial Park

23d. LOCATION (City, town, or county) (State): Allegany County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rafer Fun. Service, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 14 '60

25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9818 09798

1. PLACE OF DEATH
a. COUNTY ~~KXXXXXXXXXX~~ ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL CUMBERLAND, MD. MEMORIAL & WARWICK ARES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LA VALE
d. STREET ADDRESS 13 RICHARD WAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

060

3. NAME OF DECEASED (Type or print): First KATHERINE Middle R. Last NORTH

4. DATE OF DEATH: Month SEPT. Day 21 Year 19 60

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1907
9. AGE (In years last birthday) 53 ~~XX~~ yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wilson Regester
14. MOTHER'S MAIDEN NAME: May Todd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Address: John R. North, Jr., La Vale, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 20 hrs

443X

DUE TO (b) Hypertensive CVD —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/20/60 19 ~~55~~ a to 9/21/60 19 ____, that (I) (we) last saw the deceased alive on 9/20/60 19 ____, and that death occurred at 6 55 M, from the causes and on the date stated above.

22a. SIGNATURE R. J. Williams M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 9/21/60
22c. PHYSICIAN'S NAME (Type) R. J. WILLIAMS
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9-24-1960
23c. NAME OF CEMETERY OR CREMATORY Loudon Park
23d. LOCATION (City, town, or county) (State) Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE SEP 22 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [illegible] should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9837

09799

M

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 10 Hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 8 Frost Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stella; Middle: M.; Last: Odgers

4. DATE OF DEATH: Month: September; Day: 22nd; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 25th, 1885

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Odgers

14. MOTHER'S MAIDEN NAME: Mary Jane Edwards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-01-0343

17. INFORMANT: Harry Odgers, 8 Frost Avenue, Frostburg, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure (Rt Side) — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Cardiovascular-Disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/20 1960 to 9/22 1960 that (I) ~~(last)~~ last saw the deceased alive on 9/22 1960 and that death occurred at 3 A M, from the causes and on the date stated above.

22a. SIGNATURE: John B. Davis, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/23/60

22c. PHYSICIAN'S NAME (Type): John. B. Davis

22d. ADDRESS: 2 Broadway, [illegible], Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-24-60

23c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

23d. LOCATION (City, town, or county) (State): Frostburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: L. P. Ernst
ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: SEP 26 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [illegible] should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9838

69800

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 36 Hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 119 S. Water St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara; Middle: E.; Last: Philbrooks

4. DATE OF DEATH: Month: September; Day: 28th; Year: 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 21st, 1883
9. AGE (In years lost birthday): 77 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own housework
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wintergreen Atkinson
14. MOTHER'S MAIDEN NAME: Elizabeth E. Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John Philbrooks, 119 S. Water St., F'bg. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 23 1930 to Sept 28 1930, that (I) (we) last saw the deceased alive on Sept 28 1930, and that death occurred at 9:45 P M, from the causes and on the date stated above.

22a. SIGNATURE: W Orff Lane M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept 30 1960
22c. PHYSICIAN'S NAME (Type): W. O. McLane, II
22d. ADDRESS: 167 E. Main St., Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-1-60
23c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park
23d. LOCATION (City, town, or county) (State): Frostburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. W. Durst
ADDRESS: Frostburg, Md.
25a. REC'D BY REGISTRAR DATE: OCT 3 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9839

CERTIFICATE OF DEATH

09801

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: Allegany — MARYLAND

b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Frostburg

c. LENGTH OF STAY IN 1b: 6 hrs.

d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Maryland — b. COUNTY: Allegany

c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Frostburg

d. STREET ADDRESS: R.F.D. #1, Box 38

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CUSTER — Middle SEATON — Last PLUMMER

4. DATE OF DEATH: Month 9 — Day 15 — Year 1960.

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-16-1897

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shop worker

10b. KIND OF BUSINESS OR INDUSTRY: B & O Railroad

11. BIRTHPLACE (State or foreign country): Shaft, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David H. Plummer

14. MOTHER'S MAIDEN NAME: Carrie Seaton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 213-09-6460

INFORMANT: Mr. Ausbee S. Plummer, R.F.D. #1, Box 38, Address Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO
(b): Cardio-Vascular disease — 1 year

Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost. 420.1

DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/11, 1960, to 9/15, 1960, that I last saw the deceased alive on 9/15, 1960, and that death occurred at 1 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Davis, M.D. — ADDRESS (Street, city or town, state): 2 Broadway — DATE SIGNED: 9/16/60

PHYSICIAN'S NAME (Type): John B. Davis, M.D. Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-17-60

22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

22d. LOCATION (City, or county) (State): Frostburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Burdett H. Montesano — ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 19 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

69802

9819

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE PENNSYLVANIA b. COUNTY BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN
d. STREET ADDRESS 75 X 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First EMORY Middle D. Last RALEY
4. DATE OF DEATH Month 9 Day 11 Year 1960

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-24--1896
9. AGE (In years last Birthday) 64 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES RALEY
14. MOTHER'S MAIDEN NAME EMMA ? RALEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 169-07-5365
17. INFORMANT PT'S CHART Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Pancreas
DUE TO
(b)
DUE TO
(c)

157 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Obstructive Jaundice

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7P 19___, to ____, 19___, that (I) (we) last saw the deceased alive on ____ 19___, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE Louis M Glick M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) LOUIS M. GLICK
22d. ADDRESS 126 N. SMALLWOOD STREET

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Sept.14,1960
23c. NAME OF CEMETERY OR CREMATORY Madley Cemetery
23d. LOCATION (City, town, or county) (State) Buffalo Mills,Pa.RD#1

24. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS Hyndman,Pa.
25a. REC'D BY REGISTRAR DATE SEP 15 '60
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9820 — Reg. Dist. No. 09803

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 07 Cumberland
d. STREET ADDRESS: 317 McMullen Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: C — Last: Reed

4. DATE OF DEATH: Month: September — Day: 7 — Year: 1960

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	June 22, 1911	49 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Celanese Corp.	Cumberland, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John L. Reed	Mary Walsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
No	214-07-6765	Regina Felton Reed 317 McMullen H'way Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CORONARY SCLEROSIS — -----
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19	20d. INJURY OCCURRED: While at work ☐ / Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D. — SEPT. 7, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Sept. 10, 1960	St. Mary's Cemetery	Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS	24a. REC'D BY REGISTRAR — DATE	24b. REGISTRAR'S SIGNATURE
James Stein Inc. 117 Fred. St. Cumb. Md.	SEP 13 '60	Arthur L. Rinn

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9821

09804

1

M

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 5/31/60

d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE: Maryland b. COUNTY: Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): Cumberland

d. STREET ADDRESS: Rt.3, Union Grove Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

091

3. NAME OF DECEASED (Type or print): First: Barbara Middle: Catherine Last: Rittenour

4. DATE OF DEATH: Month: September Day: 18, Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 5/5/1877

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Ownhome

11. BIRTHPLACE (State or foreign country): Bergton, Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Perry Whitmer

14. MOTHER'S MAIDEN NAME: Barbara C. DeLawder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: P.O.Box 599, Address: Cumberland,Md. Allegany County Infirmary Records

I

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), ond (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: ?

592

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause last.

DUE TO (b): Cerebral Arteriosclerosis — ?

DUE TO (c): Chronic Nephritis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile Deterioration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/31/60 19___, to 9/18/60 19___, that (I) (we) last saw the deceased alive on 9/17/60 19___, and that death occurred at @ 4:55 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James E. McLean M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 9/19/60

22c. PHYSICIAN'S NAME (Type): Dr. James E. McLean

22d. ADDRESS: 49 Greene St., Cumberland,Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-20-60

23c. NAME OF CEMETERY OR CREMATORY: Lost City Cem.

23d. LOCATION (City, town, or county) (State): Lost City, W.Va.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli Cumberland,Md.

25a. REC'D BY REGISTRAR DATE: SEP 21 '60

25b. REGISTRAR'S SIGNATURE: Clifford S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09805

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 27 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 510 CITY VIEW TERRACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FRANK — Middle: E. — Last: ROBINSON

4. DATE OF DEATH: Month: SEPTEMBER — Day: 27 — Year: 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DECEMBER 1, 1900

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Auto Tire Plant

11. BIRTHPLACE (State or foreign country): CANOE, PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES H. ROBINSON

14. MOTHER'S MAIDEN NAME: SARAH I. BURGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-10-4910

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malignant Melanoma — INTERVAL BETWEEN ONSET AND DEATH: 30 days
DUE TO
190.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/20/60 19__ to 9/27/60 19__, that (I) (we) last saw the deceased alive on 19__, and that death occurred at 10:15 PM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. RICHARD J. WILLIAMS

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-30-60

23c. NAME OF CEMETERY OR CREMATORY: Canoe Creek Cem.

23d. LOCATION (City, town, or county) (State): Canoe Creek, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR — DATE: OCT 3 '60

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9823

09806

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 5/29/59

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Allegany County Infirmary

d. STREET ADDRESS: 604 Washington Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George Middle: FLACK. Last: Sansbury

4. DATE OF DEATH: Month: September Day: 2, Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/22/1874

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Architect

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Theodore T. Sansbury

14. MOTHER'S MAIDEN NAME: Carrie Flack

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: P.O.Box 599, Address Cumberland, Md.
Allegany County Infirmary records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Hypostasis	24 Hrs
DUE TO (b)	Chronic Myocarditis	✓
DUE TO (c)	Cerebral Hemorrhage	✓

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile Deterioration & Psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/29/59, 19___, to 9/2/60, 19___, that (I) (we) last saw the deceased alive on 9/2/60, 19___, and that death occurred at @ 1:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: James E. McLean, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 9/2/60

22c. PHYSICIAN'S NAME (Type): Dr. James E. McLean

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 4, 1960

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemtery

23d. LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George,

ADDRESS: Cumberla nd, Md.

25a. REC'D BY REGISTRAR DATE: SEP 6 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Truax

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9824 09807

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY Rt. # 1
d. STREET ADDRESS: Along Rt. # 28
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle Last SHANNON

4. DATE OF DEATH: Month SEPTEMBER Day 17 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JANUARY 22, 1906

9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe fitter

10b. KIND OF BUSINESS OR INDUSTRY: W. Md. Rwy.

11. BIRTHPLACE (State or foreign country): FROSTBURG, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edgar SHANNON

14. MOTHER'S MAIDEN NAME: LOUISE Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

163 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/25/60 19___ to 9/17/60 19___, that (I) (we) last saw the deceased alive on 9/17/60, and that death occurred at 10:27 AM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/17/60

22c. PHYSICIAN'S NAME (Type): RICHARD J. WILLIAMS

22d. ADDRESS: Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/20/60

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Pk.

23d. LOCATION (City, town, or county) (State): Frostburg, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 21 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9840

09808

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg,
c. LENGTH OF STAY IN 1b: 10 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg,
d. STREET ADDRESS: 143 Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jonathan; Middle: ; Last: Sleeman

4. DATE OF DEATH: Month: Sept. Day: 9th, Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 9th, 1883

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR Months: ; Days: ; IF UNDER 24 HRS. Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Lumber Business

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Sleeman

14. MOTHER'S MAIDEN NAME: Margaret McFarland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-10-4389

17. INFORMANT Address: Wesley Sleeman, Mt. Savage, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 154X
DUE TO
(b): Rectal Hemorrhage
DUE TO
(c): Carcinoma Rectum

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: (a) 24 hrs (b) ? (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 9 1960, to Sept 9 1960, that (I) (we) last saw the deceased alive on Sept 9 1960, and that death occurred at 10:25 PM, from the causes and on the date stated above.

22a. SIGNATURE: Wm. McLane M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): W. O. McLane, "

22d. ADDRESS: 167 E. Main St., Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-12-60

23c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

23d. LOCATION (City, town, or county) (State): Frostburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: SEP 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9825 — Reg. Dist. No. 09809

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 48 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 117 COLUMBIA STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUIS — Middle Peter — Last SOTERAKOS
4. DATE OF DEATH: Month 9 — Day 17 — Year 19 60

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 24 1880
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Confectioner
11. BIRTHPLACE (State or foreign country): Sparta Greece
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Soterakos
14. MOTHER'S MAIDEN NAME: (Unknown) Stavroula

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Louis Soterakos — Address: Cumb. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO (b): CORONARY SCLEROSIS — ------
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an ~~XXXXXXXX~~ Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
DATE SIGNED: SEPT. ~~XX~~ 17, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/20/60
22c. NAME OF CEMETERY OR CREMATORY: Zion Memo. Pk
22d. LOCATION (City, town, or county) (State): Cumberland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc
ADDRESS: Cumb. Md.
24a. REC'D BY REGISTRAR — DATE: SEP 21 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9849

09810

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH — a. COUNTY: Allegheny — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Allegheny
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: E. — Last: Stephens

4. DATE OF DEATH: Month: Sept — Day: 30 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 1st, 1863

9. AGE (In years last birthday): 96 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Malloy

14. MOTHER'S MAIDEN NAME: Ellen Logsdon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Mary E. Thompson, Mt. Savage, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteria Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar 1960 to Sept 30, 1960 that (I) (we) last saw the deceased alive on Sept 29 1960, and that death occurred at 12:57 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W O'Mc Lane M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-30-60

22c. PHYSICIAN'S NAME (Type): W O'Mc Lane MD

22d. ADDRESS: Frostburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-3-60

23c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery

23d. LOCATION (City, town, or county) (State): Mt. Savage, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst — ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9841 — 09811

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 FROSTBURG
d. STREET ADDRESS: 17 W. MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First A. — Middle CHARLES — Last STEWART

4. DATE OF DEATH: Month SEPT. — Day 10, — Year 19 60

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 12, 1877

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY: MENS CLOTHING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ARCHIBALD STEWART

14. MOTHER'S MAIDEN NAME: ISABELLA ROBB

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: DORIS STEWART, FROSTBURG, MD. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

420.7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Sept 8 1960 to Sept 10 1960, that (I) (we) last saw the deceased alive on Sept 10 1960 and that death occurred at 22P M, from the causes and on the date stated above.

22a. SIGNATURE: Wm Lane M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept 12 1960

22c. PHYSICIAN'S NAME (Type): W. O. McLANE, M. D.

22d. ADDRESS: E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 9-13-60
23c. NAME OF CEMETERY OR CREMATORY: F'BG. MEMORIAL PARK
23d. LOCATION (City, town, or county) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: L. R. Durst
ADDRESS: FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: SEP 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Hawse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09812

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 78 East Mechanic Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: Abrahamson Apts. 78 East Mechanic St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: K. Last: Stott
4. DATE OF DEATH: Month: 9 Day: 12 Year: 19 60.

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/16/21
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Eckhart, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Harris
14. MOTHER'S MAIDEN NAME: Alice Hayes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: John Stott, 4813 Calvert Road, Address College Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr
DUE TO (b): Myocardial Insufficiency — ?
DUE TO (c):

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W Orm McLane M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): W O McLane M Dep
DATE SIGNED: Sept 12 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-15-60
22c. NAME OF CEMETERY OR CREMATORY: Percy Cemetery
22d. LOCATION (City, town, or county) (State): Frostburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Hafer Funeral Home 23 East Main, Frostburg, Md.
24a. REC'D BY REGISTRAR DATE: SEP 16 '60
24b. REGISTRAR'S SIGNATURE: Edna L. Krouse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9843 69813

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 3 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 14 Locust Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First H. Middle Marshall Last Tippen

4. DATE OF DEATH: Month September Day 16th, Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 19th, 1913

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Disab.-Air Force Emp.

10b. KIND OF BUSINESS OR INDUSTRY: Sheet Metal

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Tippen

14. MOTHER'S MAIDEN NAME: Clara Winebrenner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 217-10-1610

17. INFORMANT: Mrs. Bertha W. Tippen, Address 14 Locust St., Frostburg, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral accident (Hemorrhage) — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
DUE TO (b): Hypertensive Cardio-Vascular Disease — 1 year.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/14 19 60 to Sept 16 19 60 that (I) (we) last saw the deceased alive on Sept 16 19 60 and that death occurred at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John B. Davis, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/17/60

22c. PHYSICIAN'S NAME (Type): John B. Davis,

22d. ADDRESS: 2 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-19-60

23c. NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery

23d. LOCATION (City, town, or county) (State): Frostburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst
ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE SEP 20 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9826

09814

1

(M)

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 446 Baltimore Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 446 Baltimore Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle JANE Last TREVASKIS

4. DATE OF DEATH: Month September Day 30 Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 23, 1871

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Trevaskis

14. MOTHER'S MAIDEN NAME: Ruth White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Ruth Wear, Address 446 Baltimore Avenue, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): fever atrial arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b):
DUE TO
(c):

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 1960, to Sept. 30 1960, that (I) (we) last saw the deceased alive on 9/23 1960, and that death occurred at 4:AM, from the causes and on the date stated above.

22a. SIGNATURE: Elizabeth Brings M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Elizabeth G. Brings M.D,

22d. ADDRESS: 55 Greene Street, Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 3, 1960

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: OCT 5 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremotion, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9827

CERTIFICATE OF DEATH

09815

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 4/14/60

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

d. STREET ADDRESS: 12 Fifth Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Jane Last: Ullery

4. DATE OF DEATH: Month: September Day: 21, Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/12/1873

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Ownhome

11. BIRTHPLACE (State or foreign country): Frensco, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Sherman Diehl

14. MOTHER'S MAIDEN NAME: Jane Whetstone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: P.O.Box 599 Allegany County Infirmary Records Address: Cumberland,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): Cerebral arteriosclerosis — ?
DUE TO (c): Chronic nephritis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Deterioration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/14/60, 19___, to 9/21/60, 19___, that (I) (we) last saw the deceased alive on 9/21/60 19___, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: James E. McLean M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 9/22/60

22c. PHYSICIAN'S NAME (Type): Dr. James E. McLean

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-24-60

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.

23d. LOCATION (City, town, or county) (State): Cumberland,Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James F. Scarpelli Cumberland,Md.

25a. REC'D BY REGISTRAR DATE: SEP 26 '60

25b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9828

Reg. Dist. No. 09816

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 4 mos. 5 das
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 5 Park Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Brady — Middle: — Last: Unger

4. DATE OF DEATH: Month: Sept. — Day: 21 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/5/83

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mining

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Unger

14. MOTHER'S MAIDEN NAME: Frances Stotler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Effie Unger, 5 Park St., F'bg. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 422 Chronic Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): 450 General arteriosclerosis — ?
DUE TO (c): 592 Chronic Nephritis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

592

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 304 Senile psychosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 16, 1960, to Sept. 21, 1960, that I last saw the deceased alive on Sept 20th 1960, and that death occurred at 11:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED:

PHYSICIAN'S NAME (Type): James E. McLean, M.D. — 49 Greene St., Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-24-60

22c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

22d. LOCATION (City, town, or county): Frostburg, (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: L. R. Durst — ADDRESS: Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: SEP 26 60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9844

CERTIFICATE OF DEATH

09817

M

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): "Rural" Frostburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mahaley; Middle Coleman; Last Walters

4. DATE OF DEATH: Month September; Day 30; Year 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: January 6, 1872

9. AGE (In years lost birthday): 88 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Gilmore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Coleman

14. MOTHER'S MAIDEN NAME: Susan Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Irvin Walters "Son" Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Arteriosclerotic Cardiovascular Disease — years
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse lost. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 1 19 60 to Sept 30 19 60 that (I) (last) saw the deceased alive on Sept 30 19 60 and that death occurred at 2 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John B. Davis, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/30/60

22c. PHYSICIAN'S NAME (Type): John B. Davis

22d. ADDRESS: 2 Broadway Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/2/60

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park

23d. LOCATION (City, town, or county) (State): Frostburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn

ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG2/1 9-13-60 et

9845

CERTIFICATE OF DEATH

Reg. Dist. No. 09818

1. **PLACE OF DEATH**
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION: Miners' Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Wellersburg
d. STREET ADDRESS: 19X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Carl — Middle: Mason — Last: Warnick

4. **DATE OF DEATH**: Month: September — Day: 1 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 7, 1904

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Worker

10b. KIND OF BUSINESS OR INDUSTRY: Kelly Springfield Tire Co.

11. BIRTHPLACE (State or foreign country): Huntington, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph William Warnick

14. MOTHER'S MAIDEN NAME: Laura Virginia Willis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 220-10-2054

INFORMANT — Address: Mrs. Pauline Warnick, Wellersburg, Pa.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
DUE TO
(b): Cardiovascular disease — 8 Years
DUE TO
(c):

420.1

Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from Jan, 1958 to Sept 1, 1960 that I last saw the deceased alive on Sept 1, 1960 and that death occurred at 9:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Davis, M.D. — ADDRESS (Street, city or town, state): 2 Broadway — DATE SIGNED: 9/2/60

PHYSICIAN'S NAME (Type): John B. Davis — Frostburg, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/4/60 — 22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park — 22d. LOCATION (City, town, or county) (State): Frostburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles H. Wantesen — ADDRESS: Hafer Funeral Home, 23 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 7 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09819

9829

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 500 OLDTOWN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR Middle J. Last WEBER

4. DATE OF DEATH: Month SEPTEMBER Day 8 Year 19 60

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 28, 1885

9. AGE (In years lost birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): President
10b. KIND OF BUSINESS OR INDUSTRY: SOUTH CUMBERLAND PLANING MILL Lumber Co.
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS WEBER
14. MOTHER'S MAIDEN NAME: Anna CATHERINE BOPP

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-8398
17. INFORMANT: Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
490X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Occlusion — 3 days
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 19 56 to Sept 19 60, that (I) (we) last saw the deceased alive on Sept 8 19 60, and that death occurred at 3:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: D. O. Himmelwright M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/8/60
22c. PHYSICIAN'S NAME (Type): DR. O. H. HIMMELWRIGHT
22d. ADDRESS: 133 Va Ave, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-10-60
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.
23d. LOCATION (City, town, or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli
ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: SEP 13 '60
25b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9830

09820

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 13 hours
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 101 BELLEVUE HEIGHTS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EDWARD	D	WHEELER	9	8	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE		6/21/00	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Welder	CELANESE CORP.	Cumberland MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
EDWARD L. WHEELER	ANNA [illegible] Rowan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	217-10-4446	CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

DUE TO (b): Bronchial asthma — 1 days

DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause last.

241X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 19 57 to Sept 8 19 60 that (I) (we) last saw the deceased alive on Sept 7 19 60 and that death occurred at 8.40 A.M., from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22b. DATE SIGNED
Claude Durrett M.D.	☒	☐	☐	9/9/60

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR. C.E. DURRETT	236 VIRGINIA AVE.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	9/12/60	St. Peters & Pauls Cemetery	Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Cumberland, Maryland	SEP 13 '60	Arthur L. Kimes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9831 — Reg. Dist. No. 09821

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 300 N. Waverly Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

062

3. NAME OF DECEASED (Type or print): First John — Middle M. — Last Whetzel
4. DATE OF DEATH: Month Sept. — Day 15 — Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 26, 1906
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Service Station
11. BIRTHPLACE (State or foreign country): Mathias, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Whetzel
14. MOTHER'S MAIDEN NAME: Lula Strawderman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-10-1049
17. INFORMANT — Address: Mrs. John Whetzel, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	INTRAPERICARDIAL HEMORRHAGE Pending	1 Hr.
DUE TO (b)	RUPTURE OF DISSECTING ANEURYSM OF AORTA	1 Hr.
DUE TO (c)	DISSECTING ANEURYSM; TRAUMATIC	1 Month.

910.6

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): TRUCK FELL OFF JACK COMPRESSING CHEST
20c. TIME OF INJURY — Hour: 2:30 p. m. — Month, Day, Year: Aug. 15 1960
20d. INJURY OCCURRED While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Garage
20f. (City or town) (County) (State): Cumberland, Alleg. Md.

01

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: SEPT. 16, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-19-1960
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR — DATE: SEP 21 '60
24b. REGISTRAR'S SIGNATURE: Cinthia S. Kuma

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [illegible] or to burial, cremation, or removal.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09822

9832

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 31 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTIONAL: MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 523 VALLEY ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GERTRUDE Middle Last WHITMAN
4. DATE OF DEATH: Month SEPTEMBER Day 11 Year 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-19-1902
9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SILK FINISHER
10b. KIND OF BUSINESS OR INDUSTRY: DRY CLEANERS
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOSEPH MYERS
14. MOTHER'S MAIDEN NAME: ELLA SIGLER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214 05 6352
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis, Ut.
DUE TO (b): Uterus removed March '58 Cervical Ca
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Since Feb. '58

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 2-27-58 to 9-11-1960 that (I) ~~(we)~~ last saw the deceased alive on 9-11-1960 and that death occurred at 5:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. F. Williams M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-12-60
22c. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS
22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 14, 1960
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
23d. LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: SEP 16 '60
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9846 — 09823

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg,
d. STREET ADDRESS: 134 Bowery Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cambria — Middle: — Last: Williams

4. DATE OF DEATH: Month: September — Day: 13th, — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 13th, 1897

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Empl'yd Distrib.

10b. KIND OF BUSINESS OR INDUSTRY: Tobacco Bus.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel Williams

14. MOTHER'S MAIDEN NAME: Jane Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-32-8327

17. INFORMANT: Cambria Williams, Jr. — Address: 44 Charles St., Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Metastases — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.
DUE TO (b): Carcinomatosis — ± 1 yr
DUE TO (c): Gastric Antrum Carcinoma ? wide excision — ± 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus — sudden, severe, post-op

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 4/8, 1960, to 9/13, 1960, that (I) ~~(he)~~ last saw the deceased alive on 9/13 1960 and that death occurred at 11 P M, from the causes and on the date stated above.

22a. SIGNATURE: Frank T. Harrat M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9/15/60

22c. PHYSICIAN'S NAME (Type): Frank T. Harrat, II

22d. ADDRESS: 26 W. Mechanic St., Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-16-60

23c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

23d. LOCATION (City, town, or county) (State): Frostburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: L. P. Ouest — ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: SEP 19 '60

25b. REGISTRAR'S SIGNATURE: Cullen E. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9847 Item 8 Film G27 1-16-60 et

CERTIFICATE OF DEATH

09824 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 11 mos.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 219 Maple Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAZEL; Middle MELINDA; Last WILSON

4. DATE OF DEATH: Month 9; Day 6; Year 19 60

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-25-~~00~~ 1905

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Celanese Worker
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elias Skidmore
14. MOTHER'S MAIDEN NAME: Ida B. Rephorn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 214-07-1872
INFORMANT: Earl H. Wilson, 59 Bowery St, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
(b)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 5, 1960, to Sept 6, 1960, that I last saw the deceased alive on Sept 5, 1960, and that death occurred at 6 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm McLane M.D. — ADDRESS (Street, city or town, state): Frostburg Md — DATE SIGNED: Sept 7 1960

PHYSICIAN'S NAME (Type): Wm McLane M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-8-60
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park
22d. LOCATION (City, town, or county) (State): Frostburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Beulah A. Montesano — ADDRESS: Hafer Funeral Home, 23 E. Main, Frostburg

24a. REC'D BY REGISTRAR DATE: SEP 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09825

98.50

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 4 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 125 Front

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: 125 Front
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Louis — Middle: Elroy — Last: Wilson

4. DATE OF DEATH: Month: Sept — Day: 22 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 27, 1916

9. AGE (In years lost birthday): 44 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: William L Wilson

14. MOTHER'S MAIDEN NAME: Elizabeth Lockridge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W II

16. SOCIAL SECURITY NO.: 220-07-6578

17. INFORMANT Address: Ethel Wilson- Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis and Myocardial Degeneration not Specified as Rheumatic — INTERVAL BETWEEN ONSET AND DEATH: 5 Years
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute Cholecystitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 12, 1955, to Sept 22, 1960, that (I) (we) last saw the deceased alive on Sept. 16 1960, and that death occurred at 5A.M, from the causes and on the date stated above.

22a. SIGNATURE: Paul R Wilson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Sept 23, 1960

22c. PHYSICIAN'S NAME (Type): Paul R. Wilson M.D.

22d. ADDRESS: Piedmont, W. Va

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/24/60

23c. NAME OF CEMETERY OR CREMATORY: Barnard Cem

23d. LOCATION (City, town, or county) (State): Garrett County Md.

24. FUNERAL DIRECTOR'S SIGNATURE: E J Beal

ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: SEP 26 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

98-58 — 09826 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Moscow
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: 140 Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Donald — Middle: Patrick — Last: Wilt

4. DATE OF DEATH: Month: Sept — Day: 7 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 21, 1939

9. AGE (In years last birthday): 21 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Auto Store

11. BIRTHPLACE (State or foreign country): Westernport, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lee O. Wilt

14. MOTHER'S MAIDEN NAME: Mary A. Heylmun

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-38-5278

17. INFORMANT — Address: Mary A. Wilt—Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Severed Spinal Cord, Complete — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): FRACTURE OF SECOND CERVICAL VERTEBRAE — SUDDEN
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 823 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile Accident - car off

20c. TIME OF INJURY — Hour: 12:05 p. m. — Month, Day, Year: Sept 7 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Public Highway

20f. (City or town): Near Moscow (County): Allegany (State): Md

21. I certify that I take charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W O McLane M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): W O McLane M D asst

DATE SIGNED: Sept 7 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/10/60
22c. NAME OF CEMETERY OR CREMATORY: Philos
22d. LOCATION (City, town, or county): Westernport (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Boal — ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 9 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9848 09827

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 50 YEARS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institutian: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 FROSTBURG
d. STREET ADDRESS: 150 MAPLE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle Last WINNER

4. DATE OF DEATH: Month SEPT. Day 11, Year 19 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APR. 27, 1866

9. AGE (In years last birthday): 94 yrs. IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES MULLANEY

14. MOTHER'S MAIDEN NAME: HONORA COLEMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: BERNICE WINNER, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Atherosclerosis — 25 yrs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute Renal Infection

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Oct 4, 1960, to Oct 11, 1960 that (I) ~~(we)~~ last saw the deceased alive an Oct 11 1960, and that death occurred at 3:35 A.M., from the causes and an the date stated abave.

22a. SIGNATURE: Alvin J. Walters M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-12-60

22c. PHYSICIAN'S NAME (Type): ALVIN J WALTERS, M. D.

22d. ADDRESS: 48 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9-14-60

23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAELS CEMETERY

23d. LOCATION (City, town, or county) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: L. R. Durst ADDRESS: FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: SEP 14 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pag may be ned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled the funeral dire page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 a 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9833

CERTIFICATE OF DEATH

09828

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 19 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institutian: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 302 S. ALLEGANY STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELSIE Middle: Erma. Last: WINTERS

4. DATE OF DEATH: Month: SEPTEMBER Day: 20 Year: 19 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 19, 1886

9. AGE (In years lost birthday): 74 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ISSAC ANDERSON

14. MOTHER'S MAIDEN NAME: CARRIE CARPER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Cecum with metastasis — INTERVAL BETWEEN ONSET AND DEATH: appx 2yrs.

153.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebral apoplexy, post-Operative — 4 days

DUE TO (c): Arterio-sclerotic Vascular disease advanced

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 1 1960 to Sept 20 1960, that (I) (we) last saw the deceased alive on Sept 20 1960, and that death occurred at 10:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W M Faw Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Sept. 21, 1960

22c. PHYSICIAN'S NAME (Type): DR. WYLIE FAW

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 23, 1960

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George,

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 26 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Board of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59